State of New Jersey

OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MARRIAGE AND FAMILY THERAPY EXAMINERS
ALCOHOL AND DRUG COUNSELOR COMMITTEE
124 HALSEY STREET, 6TH FLOOR, NEWARK NJ

JAMES E. MCGREEVEY
Governor

PETER C. HARVEY
Attorney General

RENI ERDOS
Director

Mailing Address:
P.O. Box 45040
Newark, NJ 07101

(973) 504-6369

January 2004

Dear Potential Applicant:

This letter is being mailed to all individuals who have been certified by the Addiction Professionals Certification Board of New Jersey (APCBNJ). The last group of certificates were issued by APCBNJ on or before December 31, 2003. Beginning January 1, 2004, alcohol and drug counselors must be licensed through the Alcohol and Drug Counselor Committee (the Committee) of the State Board of Marriage and Family Therapy Examiners.

The application for State license or certification as well as the proposed regulations are enclosed. According to the APCBNJ records, you were granted certification after January 9, 1998. **Please be reminded that only those individuals who were granted APCBNJ certification on or before January 9, 1998 may qualify for license under the "grandfather clause" of the Alcohol and Drug Counselor Licensing Act (N.J.S.A. 45:2D-1 et seq.).** For those who obtained certification beginning January 10, 1998 through December 31, 2003, an initial application must be completed.

Each application contains instructions which must be followed in order to insure the processing for approval by the Committee. The application must be neatly printed in black or blue ink or typewritten. All sections of the application must be fully completed before the application can be processed. If any section of the application does not provide sufficient space for the information required, a supplemental sheet of the same size may be enclosed with the application (each supplemental sheet must be labeled with the section of the application to which it applies with the applicant name).

The non-refundable application fee is $ 75 and must be submitted in the form of a **certified check or money order made payable to "The State of New Jersey."** Following approval of the application, you will receive notification and at that time you will be required to submit the initial biennial (two-year) license fee ($180 for CADC and $250 for LCADC).

A full-face passport-style photograph must be signed and dated on the reverse side and attached to the application. **Do not staple the photograph to the application**.

Provide the number of your current APCBNJ certification, with the issue date and expiration date as required, in the top-right box on the application page.

(over)

Fully answer all questions with regard to Citizenship, Student Loan, Child Support, Medical Conditions and Criminal History. Your application may delayed or denied should your responses require further review.

The Affidavit sheet of the application must be executed and signed in the presence of a Notary Public.

CRIMINAL HISTORY REVIEW

Recent legislation requires the Division of Consumer Affairs to conduct criminal history record background checks on all health care professionals prior to the issuance of an initial license or other authorization to practice as a health care professional (N.J.S.A. 45:1-28 et seq).

Enclosed with the application is a Certification and Authorization form and instructions for completing the Criminal History Review. The form must be fully completed, executed and signed in the presence of a Notary Public and returned to the Committee office with your completed application for license or certification. The Committee will then provide you with instructions for obtaining fingerprints. Once the fingerprinting process has been completed, a full review will be conducted and a determination will be made as to your eligibility to obtain license or certification. **Please note that an application for license or certification will not be processed until the Criminal History Review is concluded.**

ADDITIONAL REQUIREMENTS FOR CURRENT APCBNJ CERTIFIED ALCOHOL AND DRUG COUNSELOR (C.A.D.C.) APPLICANTS SEEKING STATE CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR (C.A.D.C.)

1. Provide documentation of certification by the Addiction Professionals Certification Board of New Jersey as a Certified Alcohol and Drug Counselor (C.A.D.C.), with a copy of the certificate submitted with the completed application.

ADDITIONAL REQUIREMENTS FOR CURRENT CERTIFIED ALCOHOL AND DRUG COUNSELOR (C.A.D.C.) APPLICANTS SEEKING TO BE A LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR (L.C.A.D.C.)

1. Provide documentation of certification by the Addiction Professionals Certification Board of New Jersey as a Certified Alcohol and Drug Counselor (C.A.D.C.), with a copy of the certificate submitted with the completed application.

2. Complete the *Graduate Level Academic Course Work for L.C.A.D.C.* included in the application.

ADDITIONAL REQUIREMENTS FOR APPLICANTS NOT CERTIFIED BY APCBNJ BETWEEN JANUARY 10, 1998 AND DECEMBER 31, 2003

1. Complete Schedule B - *Academic and Professional Training* (Domain I through Domain V) or obtain a certified transcript for the five domains from APCBNJ.

We look forward to assisting you throughout this application process.

Thank you,

Elaine L. DeMars
Executive Director
Board of Marriage and Family Therapy Examiners
Alcohol and Drug Counselor Committee

L.C.A.D.C./C.A.D.C. State Application

Notice:

This application may be printed and completed for submission to the Alcohol and Drug Counselor Committee. The form is appropriate for anyone granted a C.A.D.C. certification after January 9, 1998, and for those who wish to apply for State certification and/or licensure.

Anyone who was certified by the Addiction Professionals Certification Board of New Jersey on or before January 9, 1998, and who may qualify for certification or licensure through the "grandfather" provision of N.J.S.A. 45:2D-16 and N.J.A.C. 13:34-2.1, will be mailed an application. If this applies to you and you have not received a "grandfather" application by March 1, 2004, you should contact the Committee office.

Attach a clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

A photograph is required with each application.

Do not use staples to attach the photograph.

State of New Jersey
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MARRIAGE AND FAMILY THERAPY EXAMINERS
ALCOHOL AND DRUG COUNSELOR COMMITTEE
124 HALSEY STREET, 6TH FLOOR, P.O. BOX 45040
NEWARK, NEW JERSEY 07101
(973) 504-6582

Please put a check in the box next to the category of licensure or certification you are seeking (check one only).

☐ Certified Alcohol and Drug Counselor (C.A.D.C.)

☐ Licensed Clinical Alcohol and Drug Counselor (L.C.A.D.C.)

Application for Licensure as a Clinical Alcohol and Drug Counselor or Certification as an Alcohol and Drug Counselor

Date: _____

A nonrefundable application filing fee of $75, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Committee maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last name | First name | Middle initial | Maiden name

2. Address

   ☐ Home: _____
   Street or P.O. Box | City | State | ZIP code | County

   _____ _____
   Telephone number (include area code) | E-mail address

   ☐ Business: _____
   Name of company | Telephone number (include area code)

   _____
   Street | City | State | ZIP code | County

   ☐ Mailing: _____
   Street or P.O. Box | City | State | ZIP code | County

3. *Social Security Number: _____ -_____ - _____

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certification or license or certificate renewal.

*Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law, N.J.S.A. 54:50-25 of the New Jersey taxation law and Section 1128 E(b)(2)A of the Social Security Act, the Committee or licensing agency to which this form is submitted is required to obtain your Social Security number. If you do not have a Social Security number, the Committee must ascertain the reason that you do not have one. The Committee is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or other agency responsible for child support enforcement and the H.I.P. Data Bank when reporting adverse actions.

You are also being asked to consent, on a voluntary basis, to the use of your Social Security number for the additional reasons stated below.

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b)), the Committee or licensing agency to which this form is submitted is requesting the voluntary disclosure of your Social Security number. If you give your consent for the use of your Social Security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Committee or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure or certification and disciplinary proceedings.

I, _____ , ☐ Consent ☐ Do Not Consent
Applicant's signature

to the use of my Social Security number for any of the additional purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the Bureau of Citizenship and Immigration Services (B.C.I.S.).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the B.C.I.S. at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual payment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for payment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No
   (1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No
   (2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No
b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No
c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No
d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of your licensure or certification.

_____ _____ _____
Applicant's name (please print) Applicant's signature Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as an alcohol and drug counselor" is to be construed to include all of the following:

a. The cognitive capacity to exercise reasonable alcohol and drug counselor judgments and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and related information to clients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of an alcohol and drug counselor, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substance" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the previous two years.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?
☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____ _____

Applicant's signature Date

8. Have you previously applied for a license or certificate as an Alcohol and Drug Counselor in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No
   If "Yes," when? _____

9. Have you ever passed an oral and/or written alcohol and drug counseling examination in New Jersey, any other state, the District of columbia or in any other jurisdiction? ☐ Yes ☐ No
   If "Yes," please attach a copy of your examination scores to this application.

10. Have you ever been convicted of a criminal offense? (Minor traffic offenses such as a parking or speeding violations need not be listed; however, motor vehicle offenses such as driving while impaired or intoxicated must be disclosed.) ☐ Yes ☐ No

    If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

11. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____
    Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

12. Have you ever been disciplined or denied a professional license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Have you ever been named as a defendant in any litigation related to the practice of alcohol and drug counseling or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

18. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of alcohol and drug counseling or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 12 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

1. What is the name and address of the high school you attended? _____
   Name of high school

   _____
   Street address City State /Country ZIP code

2. What years did you attend high school? _____

3. Did you graduate from high school? ☐ Yes ☐ No

   If "Yes," what was the date of your graduation?_____
   Month Year

   If "No," did you study to receive a G.E.D. certificate? ☐ Yes ☐ No

   If "Yes," please provide the name and address of the educational institution that issued your G.E.D. certificate and the date the certificate was issued.

   _____
   Name of educational institution

   _____
   Street address City State ZIP code

   _____
   Date certificate was issued

4. What is the name and address of the colleges or universities you have attended?

   a) _____
   Name of college or university

   _____
   Street address City State ZIP code

   b) _____
   Name of college or university

   _____
   Street address City State ZIP code

   c) _____
   Name of college or university

   _____
   Street address City State ZIP code

   d) _____
   Name of college or university

   _____
   Street address City State ZIP code

5. List all of the degrees that you have received from recognized colleges or universities. Please have each college or university forward to the Committee the **official transcript** for each degree that you have earned.

Educational institution	Inclusive years	Degree, Diploma or Certificate	Major	Date granted

Graduate Level Academic Course Work for L.C.A.D.C.

(You should supply the information on this page only if you are applying for recognition as a Licensed Clinical Alcohol and Drug Counselor.)

As set forth in the regulations, the graduate semester hours in course work will include graduate semester hours received in the following areas. Please list which courses indicated on your transcript(s) satisfy the relevant areas.

Area		Course title	Hours (Indicate semester hours)	College/University
Counseling theory and practice.	a.			
	b.			
	c.			
The helping relationship.	a.			
	b.			
	c.			
Human growth and development, and maladaptive behavior.	a.			
	b.			
	c.			
Lifestyle and career development.	a.			
	b.			
	c.			
Group dynamics, processing, counseling and consulting.	a.			
	b.			
	c.			
Assessment of individuals.	a.			
	b.			
	c.			
Social and cultural foundations.	a.			
	b.			
	c.			
Research and evaluation.	a.			
	b.			
	c.			
The counseling profession.	a.			
	b.			
	c.			
Pharmacology and Physiology.	a.			
	b.			
	c.			

(All applicants must complete Schedules A and B which have been sent to you with this application.)

Academic Degree Verification

(Only for Licensed Clinical Alcohol and Drug Counselor Applicants)

Applicant's name (please print): _____

Name appearing on transcripts or diplomas (if different from above):

_____

Social Security number of applicant: _____

College/university _____

Degree awarded: _____ Major: _____

Date degree was granted: _____

I hereby authorize the college or university above to forward a certified copy of my transcript directly to the:

State Board of Marriage and Family Therapy Examiners
Alcohol and Drug Counselor Committee
124 Halsey Street, 6th Floor
P.O. Box 45040
Newark, NJ 07101

Note: Applicants should send this form directly to the college/university with the fee required by the college or university. The application process cannot proceed until we receive the official transcript.

Date : _____

Applicant's name (please print): _____

Applicant's signature: _____

Applicant's address _____

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of:_____

County of: _____ } ss.

In completing this affidavit and application form, I swear (or affirm) that the information provided is true, including all copied documents to the best of my knowledge and belief. I understand that any omission, inaccuracies, or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Committee and may subject the applicant to other penalties.

I further swear (or affirm) that I have read N.J.S.A. 45:2D-1 et seq., together with the Rules and Regulations of the Alcohol and Drug Counselor Committee, N.J.A.C. 13:34C-1 et seq., and fully understand that in receiving licensure or certification from the Committee, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Committee.

I hereby authorize the Addiction Professionals Certification Board of New Jersey, Inc. or any other state alcohol and drug certification board, to release to the Alcohol and Drug Counselor Committee and the State Board of Marriage and Family Therapy Examiners any and all records concerning allegations of ethical or professional violations made against me during the period when I was licensed or certified by that body, or whether my licensure or certification has ever been denied, suspended or revoked.

_____
Applicant's signature

Sworn and subscribed to before me this _____

day of _____ , _____
Month Year

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

Affix Seal Here

Schedule A

Supervisor's Forms

300 Hours of Supervised Practical Training

In lieu of completing Schedule A, you may submit verification from the Addiction Professionals Certification Board of New Jersey.

Please put a check in the box next to the type of application you are submitting.

☐ L.C.A.D.C. application ☐ C.A.D.C. application

Applicant's name: _____

Supervisor(s) name: _____

You should send a photocopy of this page to **every** supervisor and/or agency that provided this training.

(All practicum hours must have been completed within the three-year period immediately preceding the submission of this application.)

Core functions of alcohol and drug counseling	Hours required	When completed (month/year)	Supervisor's signature
1. Screening	15 hours	_____	_____
2. Intake	15 hours	_____	_____
3. Orientation	15 hours	_____	_____
4. Assessment	15 hours	_____	_____
5. Treatment Planning	35 hours	_____	_____
6. Individual Counseling	35 hours	_____	_____
7. Group Counseling	35 hours	_____	_____
8. Family Counseling	30 hours	_____	_____
9. Case Management	20 hours	_____	_____
10. Crisis Intervention	15 hours	_____	_____
11. Client Education	15 hours	_____	_____
12. Referral	15 hours	_____	_____
13. Consultation	15 hours	_____	_____
14. Reports/Recordkeeping	25 hours	_____	_____

I hereby certify that the supervised hours listed above were completed as noted.

_____ _____

Applicant's signature Date

Documentation of 3,000 Hours of Related Work Experience Pursuant to N.J.A.C. 13:34C-2.3(b)

Please put a check in the box next to the type of application you are submitting.

☐ L.C.A.D.C. application ☐ C.A.D.C. application

Instructions: This form should be completed if you are applying for licensure as a clinical alcohol and drug counselor or for certification as an alcohol and drug counselor. You may make photocopies of this page. Your experience must be in a 12-core-function alcohol and drug treatment position. Experiential hours may go back only five years.

All positions being documented must be accompanied by:

- an official job description signed by your supervisor and program director
- a program description (brochure or flyer) signed by the program director
- each job must include one Supervisor Evaluation Form (included in this application)
- a current resume.

Applicant's name: _____

Employer's name:_____

Employer's address: _____

Program director: _____

Name of supervisor(s): _____

Your job title: _____ Dates of employment: _____ to _____

Please put a check in the box next to the title of the position you held. ☐ Counselor ☐ Intern ☐ Trainee ☐ Volunteer

(Note: The number of hours indicated in the answers to questions number 2 and 3 must equal the total number of hours indicated in the answer to question number 1.)

1. How many hours of supervised experience in alcohol and drug counseling are you documenting? _____

2. Of the hours documented in question number 1, how many hours in **direct** (face-to-face) client counseling are you documenting?

_____

3. Of the hours documented in question number 1, how many were spent in all other core function areas? _____

_____ _____

Applicant's signature Date

_____

Employer/ Supervisor's signature

Supervisor Information Form

Please put a check in the box next to the type of application the applicant is submitting.

☐ L.C.A.D.C. application ☐ C.A.D.C. application

Note to supervisor: The Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners believes that licensure and certification should be based on input from a variety of sources, including the observations of people who supervise the applicant. For this reason, each applicant is required to obtain an evaluation from a clinical supervisor. Your evaluation, among others, and data furnished by the applicant will be used in determining eligibility for licensure or certification. As this process can only be effective with careful and truthful reporting, all information gathered in the evaluation process is confidential.

Please return this form and the attached ratings to the address listed above. In the event that you cannot rate the applicant on the items, please indicate so, and return this form to the Committee.

The supervisor must submit a copy of his or her resume or a statement about his or her background with this evaluation.

Applicant's name: _____

Agency's name: _____

Agency's address: _____

Name of supervisor(s): _____

Title of supervisor(s): _____ Telephone number (include area code): _____

Length of time you have:

A. Known the applicant _____

B. Provided direct supervision of this applicant _____

Please complete:

I hereby certify that I have been in a position to directly supervise the above-named person's work. In my judgment, this applicant's eligibility and professional experience (check one) ☐ is ☐ is not consistent with licensure or certification standards as set forth by the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners. The information that I am providing is my best judgment of the above-named person's capabilities to be: (check one)

☐ licensed as a clinical alcohol and drug counselor, or ☐ certified as an alcohol and drug counselor.

The type(s) of supervision I have used with this counselor include those checked below.

☐ Audio/video tapes	☐ Case discussions	☐ Group supervision	☐ One-way mirror observation
☐ Case presentations	☐ Individual supervision	☐ Telephone consultation	☐ Other

_____ _____

Supervisor's signature Date

Professional licensure, degrees or certifications:_____

☐ I am a Certified Clinical Supervisor

Supervisor Evaluation Form

Please put a check in the box next to the type of application the applicant is submitting.
☐ L.C.A.D.C. application ☐ C.A.D.C. application

Applicant's name: _____

Evaluator's name: _____

Note: Please rate the applicant in each area using the following scale:

0 = No basis for judgment
1 = Inadequate
2 = Needs development
3 = Acceptable
4 = Good
5 = Outstanding

Area of knowledge, skills or competency

1) Communication
   a) Oral _____
   b) Written _____

2) Knowledge of Alcoholism/Drug Abuse
   a) Physiological _____
   b) Pharmacological _____
   c) Psychological _____

3) Evaluation and Client Assessment
   a) Knowledge of:
      i) Human growth and development _____
      ii) Family dynamics and interaction _____
      iii) Signs and symptoms of alcoholism and drug abuse _____
      iv) Signs and symptoms indicating referral for medical, psychological or other assessment _____
   b) Analytical skills:
      i) Assessing stages of alcoholism/abuse _____

Area of ethical standards

1) Orientation in all efforts towards a primary goal of recovery for the client and his or her family. _____

2) Respect for confidentiality of records, materials and communication concerning clients. _____

3) Respect for the client by maintaining an objective, nonpossessive professional relationship. _____

4) No discrimination among clients or professionals on the basis of race, color, creed, age, sex or sexual orientation. _____

5) Respect for the rights and views of other alcohol and/or drug workers and other professionals. _____

6) Respect for institutional policies and cooperation with management functions.
Initiative toward improving institutional policies and management functions. _____

7) Evidence of genuine interest in helping people with alcohol and/or drug problems and dedication to helping lead clients to methods of helping themselves as much as possible. _____

8) Willingness to access one's own personal and vocational strengths and limitations, biases and effectiveness. The ability and willingness to recognize when it is in the client's best interest to refer or release him or her to another individual or program. _____

9) Willingness to take personal responsibility for continued professional growth through further education or training. _____

10) Total commitment to providing the highest quality of care through both personal effort and the utilization of any other health professional or services which may assist the client in his or her recovery program. _____

_____ _____

Supervisor's signature Date

*** Additional comments may be made below.***

Self-Help Meeting Verification Form

Please put a check in the box next to the type of application you are submitting.

☐ L.C.A.D.C. application ☐ C.A.D.C. application

Applicant's name: _____

(Specified below are the minimum number of self-help meetings required for this application.)

Minimum Number of Meetings Required:

A.A. - 5 ALANON - 5 N.A. - 5 OTHER - 15

Date	**A.A. location**
1)	
2)	
3)	
4)	
5)	

Date	**ALANON location**
1)	
2)	
3)	
4)	
5)	

Date	**N.A. location**
1)	
2)	
3)	
4)	
5)	

Date	**Name of other self-help groups** (Can include additional A.A., ALANON, N.A. groups or other self-help g roups.)
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	
11)	
12)	
13)	
14)	
15)	

As required for licensure as a clinical alcohol and drug counselor or certification as an alcohol and drug counselor in the State of New Jersey, I certify that I have attended the meetings listed on this form.

_____ _____

Applicant's signature Date

As the applicant's supervisor, I certify that the applicant has provided documentation that he or she has attended the meetings listed above.

_____ _____

Supervisor's signature Date

Schedule B

Academic and Professional Training

(This schedule must be completed and accepted before you sit for the exam.)

Please complete the following pages and submit them with your application or obtain a certified transcript for the five domains from the Addiction Professionals Certification Board of New Jersey.

Name: _____

Mailing address: _____

Daytime telephone number (include area code) _____

If applicable:

Addiction Professionals Certification Board of New Jersey (A.P.C.B.N.J.) information.

Certified Alcohol and Drug Counselor number (C.A.D.C.): _____

Initial date: _____ Expiration date:_____

- You must attach a copy of your degree(s), if applicable.
- You must attach copies of course certificates in order for the Committee to review your course work.
- Course certificates must be clearly marked and placed in sequential order (i.e., all domains together, all education topics in order, etc.).
- In lieu of completing Schedule B, you may submit a copy of your current Certified Alcohol and Drug Counselor certificate or an official transcript from the Addiction Professionals Certification Board of New Jersey. You must complete this first page.

Course work is as follows:

Course Work Domain I-

Initial Interviewing Process
Biopsychosocial Assessment Differential Diagnosis
Pharmacology-Physiology of Substance Abuse
(formerly included in Biopsychosocial)
Diagnostic Summaries
Compulsive Gambling

Course Work Domain II-

Introduction to Counseling
Introduction to Techniques and Approaches
Crisis Intervention
Individual Counseling
Group Counseling
Family Counseling

Course Work Domain III-

Community Resources
Consultation
Documentation
H.I.V. Positive Resources

Course Work Domain IV-

Addiction Recovery
Psychological Client Education
Biomedical Client Education
Sociocultural Client Education
Addiction Recovery and Psychological Family Education
Biomedical and Sociocultural Family Education
Community and Professional Education

Course Work Domain V-

Ethical Standards
Legal Aspects
Cultural Competency
Professional Growth
Dimensions of Recovery
Supervision and Consultation
Community Involvement

Domain I-Assessment

Required: A total of 54 clock hours including all of the topics listed at the bottom of this page with a minimum of six hours in each category.

Name: _____

	Course name	School or agency sponsor	Total clock hours	Dates attended
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				

I hereby swear that the information provided above is true to the best of my knowledge.

_____ _____

Applicant's signature Date

For Committee Use Only

Requirement fulfilled:

_____ Initial Interviewing Process

_____ Physiology/Pharmacology of Substance Abuse

_____ Compulsive Gambling

_____ Biopsychosocial Assessment Differential Diagnosis

_____ Diagnostic Summaries

Domain II-Counseling

Required: A total of 54 clock hours including all of the topics listed at the bottom of this page with a minimum of six hours in each category.

Name: _____

	Course name	School or agency sponsor	Total clock hours	Dates attended
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				

I hereby swear that the information provided above is true to the best of my knowledge.

_____ _____

Applicant's signature Date

For Committee Use Only

Requirement fulfilled:

_____ Introduction to Counseling

_____ Introduction to Techniques and Approaches

_____ Crisis Intervention

_____ Individual Counseling

_____ Group Counseling

_____ Family Counseling

Domain III-Case Management

Required: A total of 54 clock hours including all of the topics listed at the bottom of this page with a minimum of six hours in each category.

Name: _____

	Course name	School or agency sponsor	Total clock hours	Dates attended
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				

I hereby swear that the information provided above is true to the best of my knowledge.

_____ _____

Applicant's signature Date

For Committee Use Only

Requirement fulfilled:

_____ Community Resources

_____ Consultation

_____ Documentation

_____ H.I.V. Positive Resources

Domain IV-Client Education

Required: A total of 54 clock hours including all of the topics listed at the bottom of this page with a minimum of six hours in each category.

Name: _____

	Course name	School or agency sponsor	Total clock hours	Dates attended
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				

I hereby swear that the information provided above is true to the best of my knowledge.

_____ _____

Applicant's signature Date

For Committee Use Only

Requirement fulfilled:

_____ Addiction Recovery

_____ Biochemical/Medical Client Education

_____ Addiction Recovery and Psychological Family Education

_____ Community and Professional Education

_____ Psychological Client Education

_____ Sociocultural Client Education

_____ Biomedical and Sociocultural Family Education

Domain V-Professional Responsibility

Required: A total of 54 clock hours including all of the topics listed at the bottom of this page with a minimum of six hours in each category.

Name: _____

	Course name	School or agency sponsor	Total clock hours	Dates attended
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				

I hereby swear that the information provided above is true to the best of my knowledge.

_____ _____

Applicant's signature Date

For Committee Use Only

Requirement Fulfilled:

_____ Ethical Standards

_____ Cultural Competency

_____ Dimensions of Recovery

_____ Community Involvement

_____ Legal Aspects

_____ Professional Growth

_____ Supervision and Consultation

State of New Jersey

OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MARRIAGE AND FAMILY THERAPY EXAMINERS
ALCOHOL AND DRUG COUNSELOR COMMITTEE
124 HALSEY STREET, 6TH FLOOR, NEWARK NJ

JAMES E. MCGREEVEY
Governor

PETER C. HARVEY
Attorney General

RENI ERDOS
Director

Mailing Address:
P.O. Box 45040
Newark, NJ 07101
(973) 504-6369

Dear Applicant:

Recent legislation requires the Division of Consumer Affairs to conduct criminal history record background checks of all health care professionals prior to the issuance of an initial license or other authorization to practice a health care profession (N.J.S.A. 45:1-28 et seq). In order for the Division to conduct a criminal history record background check, you must complete the enclosed Certification and Authorization Form and return it to the Board or Committee at the mailing address above.

Upon receipt of the completed Certification and Authorization form, the Board or Committee will forward to you information you will need to have your fingerprints recorded. The recording of your fingerprints is necessary to conduct the criminal history record background check. Please note that you will be required to pay a $78.00 fee for this service.

Sincerely,

Elaine L. DeMars
Executive Director

Official Use Only

License Type

_____

Applicant's Number

_____

State of New Jersey
Department of Law & Public Safety
Division of Consumer Affairs
State Board of Marriage and Family Therapy Examiners
Alcohol and Drug Counselor Committee
P.O. Box 45040
Newark, New Jersey 07101
(973) 273-8050

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form and sign it in the presence of a notary.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (Last) _____ (First) _____ (Middle) (_____ Maiden Name)

2. Address _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (ZIP code)

3. Date of birth __ __ / __ __ / __ __ (Month / Day / Year) Sex: ☐ Male ☐ Female

4. Social Security number _____ / _____ / _____

5. Have you ever been convicted of a crime or an offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

Every such conviction on record must be disclosed. A true copy of every judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____ } ss.

I, _____ , in making this application to the Board or Committee for certification or licensure, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

_____
Signature of applicant

Sworn and subscribed to before me this _____

day of _____ , _____
Month Year

Affix Seal Here

_____
Name of Notary Public (please print)

_____
Signature of Notary Public